STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155756	A. BUILDING 00 B. WING	05/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY MEADOWS	7843 W JEFFERSON BLVD FORT WAYNE, IN 46804

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F0000	This visit was for the Investigation of Complaints IN00107306 and IN00107732. Complaint IN00107306 - Substantiated. Federal/state deficiencies related to the allegations are cited at F514 and F176. Complaint IN00107732 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F514. Survey dates: 5/14-15/12 Facility number: 004945 Provider number: 155756 AIM number: 200814400 Survey team: Ellen Ruppel, RN Census bed type: SNF: 29 SNF/NF: 105 Total: 134 Census payor type: Medicare: 32 Medicaid: 72 Other: 30 Total: 134 Sample: 6	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Due to relative low scope and severity of this survey, this facility respectfully requests a desk review in lieu of a post-survey revisit on or after June 8, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 5/18/12 by Suzanne Williams, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interviews and record review, the facility failed to notify the Physician/Nurse Practitioner of the results of a stat (immediate) laboratory test result, delaying the treatment for an	F0157	**F 157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** It is the practice of this facility to ensure that stat lab results are immediately called to NP/MD by nurse once results are reported to	06/08/2012

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	elevated blood potassium level. This deficient practice affected 1 of 6 residents whose records were reviewed for timely reporting of laboratory results in the sample of 6. Resident B Findings include: The closed clinical record of Resident B was reviewed, on 5/14/12 at 11:30 a.m., and indicated the resident had been admitted to the facility 2/2/12. His diagnoses included, but were not limited to: dysphagia, dementia, urinary retention with neurogenic bladder and anemia. Review of the orders written by the Nurse Practitioner (NP), on 4/18/12, indicated she had ordered a blood electrolyte laboratory test and a urinalysis with culture and sensitivity to be done on 4/19/12. The urinary test, which returned 4/20/12, indicated the presence of e-coli (bacteria), and the nursing note on the laboratory form indicated the resident was on Rocephin antibiotic for pneumonia. The NP ordered a "STAT" (immediate) blood test for hyperkalemia on 4/20/12 (a Friday). The specific time was not recorded on the order. The lab report indicated the blood was collected at 11:50 a.m., on 4/20/12, and the report was faxed		the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident B was discharged from facility and did not return. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · No other residents were found to have been affected by the alleged deficient practice. · All residents receiving laboratory services have the potential to be affected. · The Staff Development Coordinator/Designee will in-service Licensed Nursing staff by June 8, 2012. In-service will include facility policy: o reviewing labs when received in facility for any abnormal values; o reporting abnormal values to NP/MD; o initialing the lab with date and time; o notifying the responsible party of the abnormal lab value and any subsequent physician orders; o document information in progress note of the abnormal value, any new physician orders	

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	back to the facility at 2:52 p.m., on 4/20/12. The test indicated the resident's potassium level was high at 5.9 (normal being 3.5-5.1). The 4/20/12 lab test had been initialed by the NP on 4/23/12. During an interview with the NP, on 5/14/12 at 2:00 p.m., she indicated she had been in the facility on Monday 4/23/12, and realized the blood test was not available, so she called the lab and had the results faxed. She indicated when she saw the potassium level was 5.9, she ordered an immediate dose of Kayexalate 30 grams (to decrease the potassium level) and a repeat of the serum potassium to be done the next day (4/24/12). She indicated she would have ordered the Kayexalate on 4/20/12, if the results of the test had been called to her. The potassium level in Resident B's blood on 4/24/12 was reported as 6.7 and he was sent to the hospital for evaluation and treatment at 11:38 a.m. This federal tag relates to Complaint IN00107732. 3.1-5(a)(2) 3.1-5(a)(3)		and notification of responsible party of the above information . **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:** · All licensed nurses will be re-educated to facility policy by Staff Development Coordinator (SDC)/Designee to include: o reviewing labs when received in facility for any abnormal values; o reporting abnormal values to NP/MD; o initialing the lab with date and time; o notifying the responsible party of the abnormal lab value and any subsequent physician orders; o document information in progress note of the abnormal value, any new physician orders and notification of responsible party of the above information . · Nursing Unit Managers will check lab book daily to ensure lab results are received and physician is notified timely. This practice will occur 7 days a week to include weekends. · The Staff Development Coordinator/Designee will in-service Licensed Nursing staff by June 8, 2012. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place: · A CQI monitoring tool called Labs/Diagnostics will be utilized every week x 4, monthly x 3 and quarterly x 2. · Data will be collected by DNS/Designee and submitted to the CQI committee. If threshold is not met (100%), an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion Date: 06/08/2012**	

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F0176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on observation, interviews and record review, the facility failed to ensure one resident was assessed for self administration of medications. This deficit practice affected 1 resident in a sample of 6, whose medication regimes were reviewed. Resident F Findings include: Observation of the dining room where Resident F ate her meals, on 5/15/12 at 7:55 a.m., indicated the nurse (LPN#7) had left a medication cup with an assortment of pills in it by the place setting of Resident F. Two other residents were at the table eating their breakfast along with Resident F. LPN#7 was queried about the medications, at 7:55 a.m., and indicated Resident F had taken her potassium, but wanted to wait to take the remainder of the medications, so LPN#7 had left them on the table. The medications left were identified by LPN#7 as a multivitamin, vitamin c,	F0176	**F 176 RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE** It is the practice of this facility to ensure that only residents that have been assessed and found to be safe to administer own medications will be allowed to have meds left unattended with the resident. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident F does not have Self Administration of Medication assessment so all medications are to be given and monitored by Nursing for consumption of medications and immediately documented on the MAR. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · No other residents were	06/08/2012

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	Lasix (diuretic), alprazolam (for anxiety), and vicodin (for pain). The clinical record of Resident F was reviewed, on 5/15/12 at 10:00 a.m., and indicated the resident had scored 14 of 15 on a cognitive test. This indicated the resident was alert and oriented. There was no assessment to indicate the resident had been assessed for safe self administration of medication. During an interview with the Director of Nursing (DON) on 5/15/12, at 10:15 a.m., she indicated the medication should not have been left on the table in the dining room. This Federal tag relates to Complaint IN00107306. 3.1-11(a)		found to have been affected by the alleged deficient practice. · All residents receiving medications have the potential to be affected by the deficient practice. · The Staff Development Coordinator/Designee will in-service Licensed Nursing staff and QMA's by June 8, 2012. In-service will include Medication Policy that unless resident has valid Self Administration of Medication assessment in medical record, all medications must be monitored for consumption. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · All Licensed Nurses and QMA's will be re-educated on Medication Policy that unless resident has valid Self Administration of Medication assessment in medical record, all medications must be monitored for consumption. · The Pharmacy and Nurse unit managers will complete random observations of Medication Passes to ensure policy compliance. Observations will occur randomly 7 days a week on all 3 shifts. · The Staff Development Coordinator/Designee will	

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			in-service Licensed Nursing staff and QMA's by June 8, 2012. · DNS/Designee is responsible to oversee compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Medication Documentation will be utilized every week x 4, monthly x 3 and quarterly x 2. · Data will be collected by Nursing Managers/Designee and submitted to the CQI committee. If threshold is not met (100%), an action plan will be developed. • Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 06/08/2012**	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
	Based on observation, record review and interviews, the facility failed to ensure the complete and accurate recording of medications was implemented for 2 residents in a sample of 6, whose medication administration was reviewed. Residents D and E. Findings include: 1. Resident D was observed, sitting in a wheel chair in the hallway, on 5/14/12 at 10:20 a.m. He was identified by LPN #6 as being recently admitted from the hospital. The clinical record of Resident D was reviewed, on 5/14/12 at 10:30 a.m., and when the Medication Administration Record (MAR) was reviewed at 10:35 a.m., on 5/14/12, the 8:00 a.m.,	F0514	**F 514 RESIDENT RECORDS – COMPLETE/ACCURATE/ACCESSIBLE** It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident D's Medication Administration Record accurately reflects the medications are given as directed by the physician's orders.	06/08/2012

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	medications had not been recorded as given. The medications included hydrochlorthiazide (diuretic and anti-hypertensive), lamotrigine (an anticonvulsant), levitracetam (an anticonvulsant), magnesium oxide (a mineral), metformin (for diabetes), omeprazole (for reflux), potassium (an electrolyte), Januvia (for diabetes), Lexapro (for depression), a multivitamin, amlodipine besylate (an antihypertensive), aspirin and Decadron (a cortisone). LPN #4 was queried, on 5/14/12 at 10:40 a.m., about the morning medications being given. She indicated she had given the medications, but had not signed the MAR immediately after she gave them. She indicated she had "gotten busy" and failed to sign the MAR. 2. The clinical record of Resident E was reviewed, on 5/15/12 at 8:15 a.m., and indicated the resident was receiving aspirin daily due to having a pacemaker, metoprolol for hypertension, and citalopram for depression. The medications were scheduled for daily at 8:00 a.m. Review of the MAR for the pervious day (5/14/12) indicated the morning medications had not been initialed as given. The nurse (LPN#7) who had		· Resident E's Medication Administration Record accurately reflects the medications are given as directed by the physician's orders. · All Nursing Staff and QMA's were in-serviced on facility policy regarding medication administration by Staff Development Coordinator by June 8, 2012. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · No other residents were found to have been affected by the alleged deficient practice. · All residents receiving medications could potentially be at risk. · Staff Development Coordinator/Designee will provide in-service training to all licensed nursing staff and QMA's by June 8, 2012. In-service will include but not limited to accurate documentation noted on MAR/TAR of medications administered, and documented immediately after medication administration. **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	

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	worked on Resident E's unit the previous day, was queried about the medications, on 5/15/12 at 8:45 a.m., and indicated she had given the 5/14/12, 8:00 a.m. medications, but had not signed the MAR. 3. The facility's policy for medication administration, dated 1/2010, was provided by the Director of Nursing (DON) on 5/14/12 at 2:30 p.m. The policy indicated, in part, "21. Medications will be recorded on the MAR or TAR after given." The policy did not specify immediately after given. 4. The 2010 Nursing Spectrum Drug Handbook was reviewed, on 5/15/12 at 2:30 p.m., and indicated, on page XV preface and user's guide, in the area of additional nursing responsibilities, "After giving the drug, always document that it was administered. Document the dose as soon as it is given...." This federal tag relates to Complaints IN00107306 and IN00107732. 3.1-50(a)(1) 3.1-50(a)(2)		**practice does not recur:** · Medication Administration Records will be monitored by DNS/designee daily on all three shifts to ensure documentation of medication administration is accurate and timely. · Staff Development Coordinator/Designee will provide in-service training to all licensed nursing staff and QMA's by June 8, 2012. In-service will include but not limited to accurate documentation noted on MAR/TAR of medications administered, and documented immediately after medication administration. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Medication Documentation will be utilized every week x 4, monthly x 3 and quarterly x 2. · Data will be collected by DNS/Designee and submitted to the CQI committee. If threshold is not met (100%), an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination.	

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